Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges

Center for Consumer Information and Insurance Oversight

FOA: IE-HBE-11-004

Project Abstract

Application Title: Kentucky Level I Health Insurance Exchange Funding Solicitation
Organization: Cabinet for Health and Family Services
Program: Health and Human Services Cooperative agreement to Support Establishment of State Operated Health Insurance Exchange, Funding Opportunity Number IE-HBE-11-004
Project Director: Carrie Banahan
Congressional Districts Served: KY-01, KY-02, KY-03, KY-04, KY-05, KY-06
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Organization website: www.chfs.ky.gov and http://healthcarereform.ky.gov
Category of Funding: Level One **Projected Date of Completion:** August 14, 2012

The Kentucky Cabinet for Health and Family Services (CHFS) is applying for a Level One Establishment Grant from the Center for Consumer Information and Insurance Oversight through the Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges. This funding will allow Kentucky to continue planning efforts for an Exchange. CHFS is collaboratively working with the Office of Administrative Technology (OATS), Department for Medicaid Services, Department for Community Based Services (DCBS) and the Kentucky Department of Insurance (KDOI).

CHFS consists of a majority of the state's human services and health care programs, including the Department for Medicaid Services (DMS), Depart for Community Based Services (DCBS), Commission for Children with Special Health Care Needs (CCSHCN), and the Department of Public Health (DPH) who will be working in collaboration with the Department of Insurance (DOI) in the planning process for an exchange.

Kentucky has a population of 4.2 million citizens. Based on background research, the estimated total number of Kentuckians who might access the Exchange for their health care coverage is between 1.0 and 2.4 million. This estimate was from the highest number of potential users of the Exchange from the commercial market and uninsured population, and many factors may affect actual participation.

This grant application contains a request for funding to continue Kentucky's planning of an Exchange. The Exchange planning will be closely coordinated with planning for a new Medicaid eligibility and enrollment system through a PAPD with CMS. A significant portion of the grant request will be utilized for Information Technology systems (IT), including the definition of requirements, the procurement of an IT planning vendor, assistance with drafting an RFP for procurement of IT upgrades/and or new systems. Additional funding has been requested for the areas of financial management, program integrity, sustainability, actuarial services, consumer assistance and staff support. Kentucky's total request for funding is $7,670,803.

Object Class Category	Federal Funds	Justification
Lead Project Staffing (Cabinet for Health and Family Services)	$148,007	Lead Point of Contact - Executive Director/Project Manager (Carrie Banahan)- Responsible for overall operation of the project; oversees staff performance, interagency coordination, contracting, and reporting 50%@ $100,000 x 10.5 months = $43,750 Staff Assistant (Brenda Parker) - Responsible for project oversight, interagency coordination, quality reviews, research and report writing, work plan subsidiary project lead 100% @ $55,000 x 10.5 months = $48,125 Program Coordinator (Sherilyn Redmon) – Research and report writing, budget preparation, work plan subsidiary project lead 100% @ $42,650 x 10.5 months = $37,319 Health Policy Specialist II (Kris Hayslett) – Research and report writing, project support, work plan subsidiary project lead 50%@ $43,000 x 10.5 months = $18,813 Note: All of the above positions were included in the Exchange Planning Grant: therefore, the first month and ½ of each position are still being paid through that grant. So, only 10.5 months of salary have been requested within this grant application.
Support Staff (Department of Insurance)	$42,000	Director, Health and Life Insurance Division (William Nold)- Oversees staff performance, interagency coordination, contracting and reporting, legal research for state operated and regional exchanges. 20%@ $79,740 x 10.5 months = $13,955 Health Policy Specialist II (Voin Barker II) - Research for market commonalities in surrounding states, analysis of complex issues related to the Exchange, reviews inter-operability of system development 15% @ $42,816 x 10.5 months = $5620 Staff Attorney III (Andrea Fegley) - Legal research, drafts and reviews legislation and administrative regulations, reviews Exchange policy options for compliance with existing state law 15%@ 52,500 x 12 months= $7875 Insurance Program Manager (Melea Rivera) – Research and report writing, utilizes insurance knowledge and experience to evaluate and recommend policy options for the Exchange. 15%@ 44,892x 12 months= $6734

		Administrative Branch Manager (Jill Mitchell) – Research and report writing, utilizes insurance knowledge and experience to evaluate and recommend policy options for the Exchange. 15%@ $52,104 x 12 months= $7816 Note: Two of the above positions were included in the Exchange Planning Grant: therefore, the first month and ½ of each position are still being paid through that grant. So, only 10.5 months of salary have been requested within this grant application for those 2 positions.
Consumer Assistance Program	$222,264	Consumer Ombudsman (Vacant) – This position is already established and is primarily responsible for assisting consumers, providing information, organizing educational seminars, handling consumer issues, and referring consumers to the proper agency when necessary. 100%@ $56,540 x 10 months = $47,117 Administrative Specialist (Rebecca Hubbard) – Provide administrative support to the ombudsman, track data related to the consumer assistance program, and assist in the development of consumer literature. 100%@ $35,039 x 10 months = $29,199 Healthcare Data Administrator (Vacant)– Responsible for assisting consumers, providing information, organizing educational seminars, handling consumer issues, and referring consumers when necessary, track data related to the consumer assistance program, and assist in the development of consumer literature. 100%@ $62,145 x 10 months = $51,788 Internal Policy Analyst IV (Vacant) – Researches consumer issues for corresponding legal stance, recommends policies and procedures, assists consumers, and handles consumer issues track data related to the consumer assistance program, and assist in the development of consumer literature. 100%@ $56,496 x 10 months = $47,080 Insurance Program Manager (Vacant) – Responsible for overall operation of the program, oversees staff performance, manages program to ensure compliance with laws and regulations, recommends program changes and changes in laws, and assist in the development of consumer literature. 100%@ $56,496 x 10 months = $47,080 Note: For the first two already existing positions, funding provided by the Consumer Assistance Program grant ends October 14. Therefore, funding through the Exchange begins 10/15. Additionally, a hire date of October 15 is anticipated for 3 new positions presented above. Therefore, 10 months of salary have been requested within this grant application.
Fringe Benefits	$187,789	Fringe (27%)

		FICA (7.65%) Health (5%) Retirement (4.9%) Life (1%) For Lead Point of Contact $19,928 For Staff Assistant $21,921 Program Coordinator $16,999 For Health Policy Specialist II $8,569 For Support Staff $19,131 For Consumer Assistance $101,241
Travel (out of state)to HHS/OCIIO Exchange related conferences (cost of $1712/person) Travel (in-state)	$50,630	HHS/OCIIO Flight= $1000 per flight/5 staff = $5000 Lodging= $280 per day/5 staff@2 days= $2800 Per Diem= $36 per day x 5 staff @ 2 days= $360 Parking/Misc=2 days @ 5 staff/$40 day = $400 Total $8560 Total x 5 trips = $42,800 Staff from OHP, DOI, and OATS may all attend various Exchange-related opportunities Mileage & per diem for in-state travel to meetings, conferences, off site work areas, etc. Mileage = 5 people (2 vehicles) x 6 trips x 400 miles (avg) x .40/mile = $1920 Per Diem = 5 people x $36/day x 6 trips x 2 days = $2160 Lodging = 5 people x 1 night x $75/night x 6trips = $2250 Total $6330 10 trips (site areas, vicinity) x 5 people x 75 miles (avg.) x .40/mile = $1500
Stakeholder Public Forums	$10,000	Facility charges (meeting rooms): $5,000 Hotel rooms (only when one-day travel is not possible): $500 Equipment rental: $200 Refreshments: $1,000 Misc. (state vehicles, comp time, etc.): $300 Speakers $1000

		Printing costs $2,000 Total $10,000
Business Operations/Exchange Functions	$3,400,000	KY will amend an existing contract to obtain the services of Accenture. The scope of work provides the information required by the Commonwealth to determine the feasibility of operating a State Exchange, including business models, operational and administrative requirements, and the technology requirements to support the Exchange and meet the relevant federal milestones. In the event that the Commonwealth elects to proceed with development of the Exchange, the vendor would assist the Commonwealth in developing an RFP. Period of performance will be from August 15, 2011 – July 15, 2012. Contractor will report directly to the Project Manager, who will evaluate performance and maintain oversight of contract expenditures. Contract has yet to be formally defined.
Actuarial Services	$1,000, 000	Contracted actuaries will perform the following: - Assist with review and analysis of policy options under ACA, expand definition of small group to 100, establishment of Basic Health Program, define health benefit plans offered in Exchange, etc. - Analyze financial, statistical and mathematical data and perform actuarial calculations; - Assist in the financial planning and forecasting process; - Track industry trends, develop internal models and evaluate programs that will be used to make critical decisions; and - Work in collaboration with various internal teams to identify process changes and enhancements to healthcare and the Exchange
Financial Management Structure	$140,000	Contractor to develop a financial management plan for the Exchange.
Sustainability	$160,000	Contractor to develop options for sustainability and estimate operational cost.
Program Integrity	$150,000	Contractor to develop program integrity plan for the Exchange.
IT Systems Planning and Development	Total IT contract costs $1,647,403	Through existing IT contracts, will obtain staff for IT systems planning and development. Current IT Consultant (Theresa Glore) - responsible for overall operation of the IT project; oversees interagency coordination, contracting, and reporting. Has extensive knowledge of Exchange requirements. Main IT presence on the Exchange Team. The first month and ½ of her salary is paid through the Exchange Planning Grant. 100% @ $131,400 x 10.5 months = $114,975 Project Manager (Vacant) – Requires two years experience in managing project teams for large scale web based projects and data management projects. Responsible for managing the development and implementation of the project. Keeping track of deliverables, time-lines, and issues for the project. Project Manager is budgeted at the level of a certified project manager and will oversee technology aspects of the project. 100%@ $145,596 x 12 months = $145,596

		2 Technical Architects (Vacant) – Requires Masters Degree with at least five years experience or Bachelors Degree with at least seven years of experience functioning as a technical architect for large scale web based .Net projects and data integration and management projects. Will act as single point of responsibility for the technical solutions from an application and system perspective. Define technical architecture, resolve technical issues, and ensure that all components of the technical architecture are properly integrated and implemented. Define the development tools and the environment. Coach the technical team in development of the technical architecture. Provide technical support and technical quality control throughout all stages of the project. Coordinate vendor services related to technology selection and implementation. 100%@ $156,000 x 12 months x 2 persons = $312,000 3 Business Analysts (Vacant) - Requires minimum of three years experience in working with web-based development projects and data management projects. Responsible for development of business requirements documentation. Analysis of business requirements and development of functional specifications for the developers and architects. Integration testing of the software application to assure delivery of an error free application that meets the business needs as defined in the requirements. 100%@ $114,400 12 months x 3 persons = $343,200 Reporting/Auditing Specialist (Vacant) - Requires Masters Degree with at least three years of experience or Bachelors Degree with at least five years reporting/auditing experience working with large scale IT systems. Must have experience in working with reports generation systems/tools and systems audit software. Prefer prior experience in systems security and compliance with federal and state privacy and security laws and regulations. 100%@ $124,800 x 12 months = $124,800 Subject Matter Expert (Vacant) - Requires Masters Degree with at least three years of experience or Bachelors Degree with at least five years experience in health policy arena; prefer direct experience in health plan analysis, management, or regulation to serve as a subject matter expert to the Exchange IT team. 100%@ $135,204 x 12 months = $135,204 2 .NET Developers (Vacant) - Requires Masters Degree with at least three years of experience or Bachelors Degree with at least five years experience in development of large scale web based projects and data integration management projects. Responsible for development of web application and database related development of web applications. Proficiency in .NET framework, C#, SQL 2008, Java script, web development standards, etc. Development of presentation layer, business layer, and data access layers of proposed applications. 100%@ $135,198 x 12 months x 2 persons = $270,396

		PM/Contract Manager (Vacant) - Requires two years experience in managing project teams for large scale web based projects and data management projects. Responsible for managing the development and implementation of the project. Keeping track of deliverables, time-lines, and issues for the project. Project Manager/Contract Manger: is budgeted at no-certified level and will conduct business and contractual management for the project. 100%@ $131,040 x 12 months = $131,040 Total It project staff cost $114,975 $145,596 $312,000 $343,200 $124,800 $135,204 $270,396 $131,040 $1,577,211 IT project supplies and equipment General office supplies for 12 months $1000/year x 12 staff = $12,000 Laptops and Monitors $1,401.06/person x 11 persons = $15,412 Printer $375 estimated monthly charge x 12 months = $4,500 Software add-ons for developers @ $10,748.80 x 2 persons = $21,498 (Visual Studio, Visio Std, Project Std.) Software add-ons for staff @ $837.19 x 9 persons = $7,535 (Visio Std. and Project Std.) Total Supplies and Equipment $60,945 Space Rental – Office space for contractor staff @ $9,246.96 per year for 1,427 square feet @ $6.48 per square foot Total Cost of Space Rental $9,247
Outreach and Education Plan	$400,000	KY is partnering with the University of Kentucky (currently performing background research for the Exchange) to create an outreach and education plan. The short-term goals of this plan include:

		1.) Performing a Market Analysis/Environment Scan to assess outreach/education needs to determine geographic and demographic-based target areas and vulnerable populations for outreach efforts. 2.) Developing an outreach and education plan to include key milestones and contracting strategy. 3.) Distributing outreach and education plan to stakeholders for input and refinement. Outreach efforts will be tailored to the needs of the surrounding communities by leveraging UK's state-of-the-art continuing education resource, experience in healthcare education and outreach as well as maximizing the established relationships of community engagement throughout the state. Contractor will report directly to the Project Manager, who will evaluate performance and maintain oversight of contract expenditures. Contract has yet to be formally defined.
Office Supplies and Equipment	$16,700	General office supplies for 12 months $1000/year x 9 staff = $9000 Office equipment for Consumer Assistance Exchange functions 3 workstations (3 new positions) $1000 x 3 = $3000 3 Desk Chairs $200 x 3 = $600 6 Side Chairs $100 x 6 = $600 3 telephones $500 x3 = $1500 Toll-free line monthly service fee for Consumer Assistance program $200 x 10 months = $2000
Indirect Charges	$96,010	Indirect Cost Rate Agreement of 16%
TOTAL	$7,670,803	

Demonstration of Past Progress in Exchange Planning Core Areas

Background Research

To conduct the necessary background research for planning a Health Benefit Exchange in Kentucky, including assessment of the number of insured/uninsured individuals in the Commonwealth, status of the current health insurance market, and identification of the number and characteristics of potential Health Benefit Exchange users, the state's Office of Health Policy (OHP) requested assistance from the University of Kentucky (UK), with whom it has an established relationship. As a result, a Memorandum of Agreement (MOA) was drafted in January 2011, and approved in late April.

The UK MOA requires the development of a complete compilation of data sets and reports of the current insured population in Kentucky by market segment (individual, small group, large group, association and employer-organized association), including the following detail: estimates of the level of insurance; collection of specific characteristics of Kentucky's insured population, including income, age, gender, race/ethnicity, marital status, and geographic location; premiums paid and allocation of premium by employer/employee (contribution rates); take-up rate of employer sponsored insurance by employees; benefit designs of commercial coverage; and whether insurance is obtained via direct sale or with agent involvement.

Upon approval of the MOA, the UK research team began its work using data from the Current Population Survey (CPS), the American Community Survey (ACS) and the Medical Expenditure Panel Survey (MEPS). By early May, researchers estimated that 48% of Kentucky's total population (4,262,000) has health insurance through an employer, 6% purchase health insurance directly through the private market, 32% have public coverage and 14% do not have any insurance coverage. They also found that of the total population under 65 years of age (3,765,064), uninsured individuals represent 669,940 or 17.8% of the population, while 82.2% of that population are insured through individual and group policies, or receive Medicaid coverage.

To identify the widest range of potential exchange users, the UK team looked at the following:
(1) Individuals currently uninsured or purchasing insurance through the individual market who either may or may not be eligible for tax subsidies in 2014;
(2) Small businesses currently offering insurance who may be likely to come to an exchange;
(3) Small businesses currently not offering insurance; and
(4) Large businesses offering and not offering insurance.[1]

The estimated total number of Kentuckians who might access the exchange for their health care coverage is between 1.0 and 2.4 million. The estimate was for the highest number of potential users of the exchange from the commercial market and uninsured populations, and does not include individuals who will use the exchange as a means to access Medicaid benefits. In its report, the UK team noted that many factors will affect actual participation, including the state's definition of small group insurance in 2014, the number of employers that drop coverage, and many other variables. The high end of this estimate includes approximately 1.4 million individuals currently receiving employer-sponsored insurance (ESI) through their large employers. They also commented that it is important to note that the majority of these potential enrollees would have other health insurance purchase options, so actual enrollment will depend on many other factors. Following in Tables 1 - 3, are other important UK research team findings.

The large employer information is displayed by number of establishments, that is, the number of individual worksite locations, rather than the number of firms, or large corporate entities. This distinction arises because

[1] This approach is based on the work performed by the State Health Access Data Analysis Center at the University of Minnesota for the state of Indiana and was used with their permission.

large employers typically have numerous employment locations, often in different counties or state. In contrast, employers of fewer than 25 workers typically have a single location.

Table 1

Individuals	Number of Households	Number of Individuals
Must use Exchange to obtain Subsidies :		
Currently uninsured, income 139% to 399% FPG	151,724	220,000
Currently have individual coverage, income 139% to 399%	69,789	112,360
Subtotal	**221,513**	**332,360**
Not eligible for subsidies but may purchase insurance from Exchange:		
Currently uninsured, income 400% FPG or higher	46,565	61,000
Currently have individual coverage, income 400% FPG or higher	24,969	37,453
Subtotal	**71,534**	**98,453**
Grand Total	**293,047**	**430,813**

Table 2

	Employees	Dependents	Total enrollees	Number of establishments
Small Businesses Currently Offering Insurance				
Currently have ESI through a business with fewer than 50 employees	136,878	103,302	240,180	22,778
Potentially eligible for tax credit	94,893	68,228	163,121	15,067
Not eligible for tax credit	41,985	35,074	77,059	7,711
Currently have ESI through a business with 50-99 employees	68,117	51,088	119,205	2704
Total	**341,873**	**257,692**	**599,565**	**48,260**

Table 3

	Employees	Number of establishments
Small Business Not Offering Insurance		
Businesses with fewer than 50 employees not currently offering insurance	237,461	36,232
Potentially eligible for tax credit	110,543	17,731
Businesses with 50-99 employees not currently offering insurance	45,506	267
Total	**393,510**	**54,230**

Table 4

	Employees	Number of establishments
Large Group		
Businesses with 100 or more employees, currently offering insurance	983,640	22,966
Businesses with 100 or more employees, not currently offering insurance	3,747	443
Total	**987,387**	**23,409**

Notes to tables
1 Sources: American Community Survey; Medical Expenditure Panel Survey Insurance Component, 2009; data on businesses with fewer than 25 employees and average wages less than $50,000 per year from Kentucky Cabinet for Economic Development.
2 For the purpose of assessing the number of employers, it is important to distinguish between firms and establishments. An establishment is a single physical location of business. A firm may consist of multiple establishments. The vast majority of firms with fewer than 20 employees have only one establishment; larger firms are more likely to have multiple establishments.
3 Many employees at these businesses may have health insurance through other sources (such as a spouse's employer), or may already be included in the totals for uninsured and individually purchased coverage above. Caution should be exercised to avoid double-counting of potential exchange users.

Stakeholder Consultation

Historically, Kentucky has sought the input and involvement of stakeholders prior to the implementation of significant federal and state legislation. Therefore, the input and involvement of Kentucky's stakeholders relating to implementation of the Affordable Care Act was also requested. Following are three examples demonstrating past stakeholder activities.

In August and September 2010, the CHFS OHP and Kentucky Department of Insurance (DOI) hosted informal meetings of stakeholders to discuss the feasibility and operation of a Health Benefit Exchange in Kentucky. Stakeholders included representatives of consumers, health insurance agents and brokers, employers, healthcare providers, health insurers, and other interested parties. At the meetings, the importance of stakeholder involvement was iterated and additional information relating to the Act was provided. Meeting participants discussed such topics as Exchange governance and structure, operations, number and types of exchanges, and issues relating to participation in an Exchange. The relationship of the Exchange to the Medicaid Program, Kentucky Child Health Insurance Program (KCHIP), and other public programs was explained and discussed, as well as requirements relating to the need for a uniform application, initial enrollment, qualified health plans, and the Navigator program. Although these roundtable discussions were hosted primarily to obtain valuable background information, meaningful input relating to Exchange planning resulted and many commented that a state-specific exchange may be necessary to meet the needs of Kentucky citizens.

To provide another mechanism for soliciting the input and involvement of stakeholders, Kentucky established a state healthcare reform website (healthcarereform.ky.gov) in April 2011. The website provides resources for accessing information relating to all provisions of the Affordable Care Act, and includes a link to the federal healthcare reform website (HealthCare.gov) for information such as recently awarded federal grants for planning and establishing exchanges and current healthcare reform events. The Kentucky website also provides a mechanism for submitting comments and inquiries, and requesting eAlerts, which include "consumer selected information," which can be sent automatically to an e-mail account or mobile phone.

Additionally, the OHP issued a letter to 45 stakeholders, including representatives of insurance agents and brokers, businesses, consumer advocates, health insurers, healthcare professionals, and other interested parties, in April 2011. The purpose of the letter was to solicit written comments, issues, and concerns relating to the establishment of a Kentucky-specific exchange, including Exchange eligibility, functions, insurer participation, market rules, qualified health plans, risk sharing, structure and governance, financing, and consumer education and outreach. A total of 22 responses from targeted stakeholders, as well as other interested parties, were received for a response rate of 48.9%. Upon final analysis, a report of findings will be developed for use in the creation and establishment of a Health Benefit Exchange in Kentucky.

State Legislative/Regulatory Actions

Since September 2010, much time has been spent conducting comprehensive reviews and analyses of the Exchange "enabling" legislation of other states, including bills and executive orders introduced, pending, or enacted in early 2011, in states similar to or bordering the Commonwealth. A review of the American Health Benefit Exchange Model Act developed by the National Association of Insurance Commissioners (NAIC) was also conducted.

Governance

At this time, the governance and structure of the Kentucky Health Benefit Exchange has not been determined; however, the DOI, DMS and OHP have attended several national conferences which provided information relating to various options for governance and a portion of Kentucky's Exchange planning grant funds was used by OHP to develop an issue brief relating to this topic. The brief is in its final stages of drafting and upon completion, will provide not only an analysis and discussion of the various options for establishing an Exchange governance, but also provide recommendations for consideration by CHFS executive management, policymakers, and other stakeholders.

Relating to the establishment of a regional Exchange, the DOI has analyzed and is currently reviewing the various advantages and disadvantages of this exchange type. The DOI has also discussed the feasibility of a multi-state operation with other states, including states contiguous to Kentucky. It is unclear at this time, however, due to the variability in state insurance statutes and regulations. To administer a regional Exchange among these states may be too burdensome if states are unwilling to amend existing laws for purposes of establishing a regional exchange. The NAIC is aware of this issue and is in the process of developing a specific white paper regarding issues associated with governance and may provide some guidance with respect to this issue in the near future.

Although various options for operating an Exchange are allowed under the ACA, including an Exchange (1) housed within an existing state office, (2) operating as an independent public authority, or (3) operating as a nonprofit entity, the most advantageous option for Kentucky remains unclear. However, at this time, Kentucky continues to weigh the advantages and disadvantages of each option and contemplates the development of a stand-alone, quasi-governmental Exchange. The rationale behind this structure is rooted in the fact that no current state agency exists, or has the capacity to administer and perform all business operations and integration functions required under an Exchange; however, a number of state agencies have limited capacity for operating and supporting an Exchange. Additionally, state agencies currently involved in the Exchange planning process will be positively impacted by the Exchange relationship.

Program Integration

Information Technology (IT), the Departments for Medicaid Services (DMS), and Insurance (DOI), as well as the Office of Health Policy (OHP) have participated in numerous vendor presentations regarding system development, system integration and business operations of an Exchange. These presentations have helped help staff understand some of the options available under Exchange systems operation, and will assist in the development of a Request for Proposal (RFP) to secure Exchange IT systems and services. These presentations have also helped with the collaborative effort among the departments to consider the Exchange and its impact upon Medicaid and other social service programs.

All Cabinet program representatives (Department of Aging and Independent Living, Office of the Inspector General, Department for Medicaid Services, Department of Community Based Services, Office of the Ombudsman, Department of Behavioral Health, Developmental and Intellectual Disabilities, and the Department of Public Health) meet monthly to update other departments of program development. The Commonwealth of

Kentucky has developed an inter-agency workgroup labeled the Exchange Team that meets. The Exchange Team currently is composed of the following individuals:

- Director, Office of Health Policy, who is also the Exchange Project Director;
- Director, Member Services and Eligibility Determination, Department for Medicaid Services;
- Director, Branch Manager, and Staff Assistant, Department of Insurance;
- Staff Assistant, Office of Health Policy, hired under the Exchange Planning grant;
- Program Coordinator, Office of Health Policy, hired under the Exchange Planning grant;
- Health Policy Specialist II, Office of Health Policy; and
- IT Consultant.

The Exchange Team has worked together to define issues of governance, information technology, and eligibility, and has also focused on the potential role of each state agency impacted by the Exchange with respect to Exchange operations. The Commonwealth is anticipating increasing the size of the Exchange Team as planning is completed and establishment activities begin to take place.

The OHP has recently drafted memorandum of agreements with both DMS and DOI with respect to roles and responsibilities of each agency for Exchange planning and development. The draft agreements are included in Attachments 1 and 2 of this document.

Exchange IT Systems

The Office of Administrative and Technology Services (OATS) provides leadership and oversight for all CHFS technology and is charged with the design, development and implementation of the technology solutions that will support the Exchange. The Executive Deputy Director of OATS serves as the Chief Information Officer for CHFS. The development of the Exchange IT systems will be supported by the Division of Systems Management, which houses the Eligibility Systems Management Branch (ESMB) and the Medicaid Systems Management Branch (MSMB).

Initiation of the planning and concept development phase began in September 2010 with the State receipt of the CCIIO Exchange Planning Grant. To support the process, OATS created a project management unit in the Division of Systems Management to include a project manager for Medicaid eligibility and enrollment systems development and a project manager for Exchange systems development. Activities to-date conducted by the project management unit include the gathering of high-level requirements, development of a gap analysis, background research that included a number of presentations by vendors and other experts in the field, and demonstrations of Exchange prototypes and state web-based eligibility systems. Considerable attention throughout the period has focused on the CCIIO/CMS Joint Technical Standards, Exchange Technical Architecture Guidance, and other federal standards for Medicaid and Exchange IT systems to assure that all applicable standards and requirements are addressed in the requirements, design, and development of the system, including standards endorsed or adopted by the Secretary of HHS pursuant to Sections 104 and 1561 of the ACA, HIPAA transaction standards, and standards to ensure accessibility as well as security and privacy standards consistent with Federal law.

The gap analysis assessed the readiness of the Cabinet's existing eligibility determination system for Medicaid and the income maintenance programs administered by Cabinet agencies to perform the operations required for implementation of the Affordable Care Act's (ACA) Health Benefit Exchange (HBE). As part of the analysis, OATS identified the high-level business requirements of the Exchange, including determination of eligibility for Medicaid and other Exchange benefits, and federal requirements and standards for Exchange/Medicaid architecture. The analysis included existing and planned technology initiatives and assets within the Cabinet as well as the proposed work that would be done by the seven states receiving federal Early Innovator grants.

The gap analysis determined that in spite of the system's competence, the Kentucky Automated Management and Eligibility System (KAMES) platform, a 17 year old legacy system that supports eligibility and enrollment for Medicaid/CHIP, does not support simplified eligibility, including web-based application and enrollment processes, and the consumer-centric usability features specified by CMS for determining eligibility and providing the 21st century customer experience required for the determination of eligibility for Medicaid and Exchange benefits.

The analysis also found that the KAMES platform does not align with the information technology framework specified by CMS, which calls for a distributive architecture and coordination of shared services supported by newer technologies as opposed to a legacy environment. It operates on the Commonwealth's IBM Z/10 model 2098-Q05 mainframe with program rules closely coupled to the core code.

Consequently, the Commonwealth does not have an existing technology infrastructure that could be rapidly deployed to support a single web-based solution that integrates the multiple aspects of health insurance enrollment and administration of financial services, including federal cost subsidies. Nor does it have an operating health benefit exchange that could be mobilized to support implementation of the ACA. This necessitates that the Cabinet pursue development aggressively in order to meet the federal milestones, which can be summarized as:

2011	Procurement; determination of systems requirements and preliminary design
2012	Systems development; user testing
2013	Final user testing; testing end-to-end integration and interfaces; deployment in time for open enrollment
2014	Implementation
2015	Exchange is self-sustainable without federal financial assistance

With the knowledge that the Commonwealth would be required to develop an IT system to support the State Exchange under a very aggressive timeframe, a number of contractors (and their state partners) were invited to provide presentations on state-of-the-art insurance exchanges and eligibility systems that are in the prototype phase or in actual operation. Early Innovator grant applications were also carefully scrutinized to identify solutions that might address the Commonwealth's needs and expedite design and development. To-date 12 vendors have provided product demonstrations, including several that are partnering with Early Innovator States.

In conducting the gap analysis, it also became readily apparent that considerable work remains to be done in developing the Exchange business model and defining the level of operational detail that is required as a precursor to design and development of the IT system. However in light of challenges to the ACA, the lack of federal guidance, or a tangible federal Exchange model, the Commonwealth has not yet confirmed that it would establish the Exchange with the result being that decisions about the specific operational aspects and administration of the Exchange have been deferred up to this point.

In preparing this grant application, the Commonwealth has determined as a result of the CCIIO mandatory milestones and the need to vigorously pursue development of the Exchange IT system that it would precede with a highly structured planning process that arrives at the level of operational and administrative detail to support system development. The services of a vendor would be engaged to implement the planning process and produce a detailed roadmap to guide development of the IT systems to support the core functions of the Exchange.

To this end, Level I Establishment Grant funding is requested to support planning leading to design and development of an Exchange IT system and a Planning Advanced Planning Document (PAPD) is being submitted to CMS to support planning leading to the design and development of a Medicaid eligibility and enrollment system. The services of a highly experienced contractor would be procured to lead two parallel planning processes that intersect at key milestones and result in an enterprise wide IT roadmap and the preparation of an Establishment Grant and RFP for the Exchange by March 31, 2012 and an Implementation Advance Planning Document (IAPD) and RFP for the Medicaid system by January 31, 2012.

Financial Management

Kentucky has recognized financial management as a key aspect of the operational plan of the Exchange. The establishment grant will be utilized to begin a complete examination of financial management and reporting necessary to support an Exchange and details are included in the business operations/Exchange functions plan.

Program Integrity

The State has not yet addressed auditing, financial integrity, oversight and prevention of waste, fraud, and abuse as it relates to the Exchange. This is part of the Level One funding request and is included in the business operations/Exchange functions plan.

Health Insurance Market Reforms

The DOI has led the initiative to implement health insurance market reforms in Kentucky. The following are the reforms and actions taken by DOI to comply with the reform requirements.

1. **No Lifetime or Annual Limits:** The DOI has required insurers to submit appropriate form filings to demonstrate compliance with the no lifetime or annual limits requirements. DOI is not aware of any insurer offering Health Benefit Plan that has not complied with this requirement by filing the appropriate forms.

2. **Prohibition of Rescissions:** This provision is currently being enforced by the Commissioner of Insurance and most insurers voluntarily complied with this requirement within six (6) month of enactment.

3. **Medical Loss Ratio (MLR):** Kentucky has submitted a letter to the U.S. Department of Health and Human Services (HHS) to request an adjustment to the MLR requirement in the individual market. That request has been accepted for review. Notwithstanding this request, Kentucky insurers are prepared to comply with the MLR requirements in accordance with the ACA.

4. **Appeals Process:** Kentucky has completed a gap analysis associated with appeals processes and has issued a bulletin requiring insurers to implement the new provisions to ensure an effective appeals process. HHS is currently reviewing Kentucky's actions to determine whether the actions are adequate to demonstrate compliance with the new appeals requirements.

5. **Annual Review of Premiums:** HHS has recently issued a proposed final rule on rate review. The DOI has conducted in-person meetings with all major insurers to discuss the rule and they have indicated that they will be able to comply with these requirements.

6. **Mandated Coverage for Preventive Health Services:** DOI requested that insurers submit modified forms to demonstrate compliance with this requirement. DOI is not aware of any insurer offering Health Benefit Plan that has not complied with this requirement by filing the appropriate forms.

7. **Extension of Non-discrimination Rules:** DOI is currently enforcing this requirement on a case-by-case basis and is unaware of any issues or violations.

8. **Mandated coverage for children under 19 years of age without imposition of preexisting condition exclusions:** The Insurance Commissioner has issued an order requiring insurers to implement an annual mandatory enrollment period for individuals qualifying for coverage under this provision. The individuals may also enroll anytime during the year if a qualifying event occurs.

9. **Mandated Coverage for Adult Children to Allow Individuals until age 26 to Remain on Parents' Insurance:** DOI has implemented this requirement and required insurers to submit modified form filings to demonstrate compliance with the requirement. DOI is not aware of any insurer offering Health Benefit Plan that has not complied with this requirement by filing the appropriate forms.

10. **Required Adherence to HHS Standards for Compiling/Providing Information to Enrollees that Accurately Describes Benefits of Coverage:** DOI is waiting for HHS to promulgate rules.

11. **Prohibits Collection and Disclosure of Gun Ownership Information to Determine Premium Rates:** DOI is currently enforcing this requirement on a case-by-case basis and is unaware of any issues or violations.

12. **Requires that Enrollee be Allowed to Select PCP (or Pediatrician for Child) from and Available Participating PCPs:** This is an existing provision in the Kentucky Insurance code and is currently being enforced.

13. **Prohibits Requirements for Prior Authorization of Increased Cost-sharing for Emergency Services or for Patient Seeking Coverage for Obstetrical/gynecological Care by a Specialist:** This is an existing provision in the Kentucky Insurance code and is currently being enforced.

Providing Assistance to Individuals and Small Business, Coverage Appeals, and Complaints

The Exchange Team has opened dialogue with both DOI and DMS discussing options for assistance to users of the Exchange. The role of Navigators, brokers, social services and other governmental personnel are under continuing discussion.

We are also examining the appeal processes currently in use by both DOI and DMS to determine whether certain functions of these processes may be shared. Kentucky will continue to refine these policies and procedures, and will develop these into official format under the establishment grant timelines. This examination will ensure that customer requests for assistance, complaints, and appeals will be coordinated across agencies to provide a seamless system to handle needs and grievances.

DOI established a Kentucky Health Insurance Advocate Program (KHIA) to assist and educate consumers and businesses of the Commonwealth with regard to health insurance coverage, access, and appeals. The program has an initial goal to create new outreach opportunities to educate consumers and businesses, serve as a resource to assist with health insurance access issues and coverage denials, and expand the Department's databases to include more detailed information on the types of issues consumers face in the health insurance market and with public insurance options. KHIA hired two staff members, a Consumer Ombudsman and an Administrative Specialist, in order to meet these goals. Continuation of this function and employment of these consumer advocates will be part of the Level One funding request.

KHIA staff are subject matter experts on the Affordable Care Act and general health insurance issues. They have developed, and are also currently in the process of developing, new consumer-friendly printed materials and website tools including appeal letter templates, educational brochures, various FAQ's, and information regarding opportunities that provide access to insurance. These materials are available on the program's dedicated website at http://insurance.ky.gov/home.aspx?div_id=16 and in the DOI Communications Office. KHIA staff are available to meet face-to-face with individual consumers and are accessible by phone and email. They are a critical component of the stakeholder outreach initiatives that will occur throughout the Commonwealth's planning activities regarding the Health Benefit Exchange.

KHIA is able to assist consumers that have not initiated or completed their insurer's internal appeal process as well as those needing help with the enrollment and application process. For those consumers that have health insurance issues outside of DOI jurisdiction (ERISA plans, Medicaid, Medicare), the KHIA provide assistance by steering the member to the appropriate agency and attempt to determine if the consumer received assistance from those agencies. Lastly, the KHIA educates consumers about the public options available to them under Medicaid, KCHIP, the Pre-Existing Condition Insurance Plan, Kentucky's high risk pool titled Kentucky Access, and, upon implementation, the Health Benefit Exchange.

Business Operations/Exchange Functions

Kentucky has demonstrated limited progress in this area; however, in the process of completing an IT gap analysis the needs for the development of Exchange business operations and Exchange functions were identified. This grant application is targeting the detailed development of these business operations and Exchange functions through the development of a work plan and specifications for acquiring IT.

Proposal to Meet Program Requirements

Throughout the Exchange implementation process, Kentucky will place great emphasis on program integration, systems development, and IT design in order for the building and testing of the Exchange to begin in calendar year 2012. Kentucky will also focus on the finalization of a structure and governance for the Exchange. The proposed work plan includes requests for IT project management, general project management, assistance with the development of business requirements, legal counsel, and drafting of planning documents and RFPs (Request for Proposal). Kentucky will continue to review the information and opportunities presented from the Early Innovator States throughout this process to determine what may function well for Kentucky. Completion of these tasks will enable Kentucky to evaluate the type of Exchange that should be implemented in Kentucky.

Background Research

The University of Kentucky will continue its work on background research and collaborate with the Commonwealth to analyze data and assist with projecting trends in the insured population, uninsured population, and market changes. UK will also work with the Commonwealth to develop and evaluate new policy options under the Affordable Care Act using economic modeling, and provide input regarding any actuarial modeling. By September 2011, based on the scope of work included in the agreement, UK will provide the Commonwealth a written report of findings and analysis of the insurance market in Kentucky.

Stakeholder Consultation

As indicated earlier in this narrative, a letter, including a standard set of questions relating to the Exchange, was issued to stakeholders in late April 2011, to solicit comments, issues, and concerns relating to a Kentucky-specific Health Benefit Exchange. Of the 45 stakeholders, 22 or 48.8% responded by the end of May 2011. An analysis of the responses will be completed and reported by July 2011. The CHFS OHP plans to make this report available to the public no later than November 2011. The report will be used to determine whether specific modifications to the current Health Benefit Exchange operational plan may be necessary to meet specific needs of Kentucky's citizens not yet identified.

Between December 2011 and June 2012, the CHFS OHP also plans to seek on-going comments, concerns and issues relating the Kentucky Health Benefit Exchange by conducting stakeholder meetings in different regions of the state for representatives of both the private and public sectors of the community. All information collected will be considered in creating a state-specific Exchange and written summaries of the meetings will be posted on Kentucky's healthcare reform website by September 2012.

Stakeholder solicitation will continue to be of benefit throughout the implementation of the exchange, and Kentucky plans to involve stakeholders in more active roles as the Exchange evolves.

Currently, no Indian Tribal governments have been identified in the Commonwealth of Kentucky; therefore, a plan for input from this particular stakeholder involvement has not been developed.

State Legislative/Regulatory Actions

To enable the creation and operation of a Kentucky Health Benefit Exchange, all options including legislation for introduction in the 2012 Regular Session of the General Assembly and Executive Order (EO) are being discussed and considered. If legislation is pursued, a bill may be drafted and shared with executive staff and policymakers as early as December 2011. Upon adoption and enrollment of this legislation, the effective date may be July 2012. If an Executive Order is determined to be a more appropriate option, no immediate legislation would be required and the effective date would be specified by the Governor.

Based upon the option selected, additional clarification of the legislation or EO may be necessary, in which case Kentucky Administrative Regulations for clarification will be drafted in July 2012, and complete the regulatory process by November 2012.

Governance

OHP's draft issue brief on Exchange governance will be provided to CHFS and DOI executive staff for review and decisions regarding the governance and structure of the Exchange. The issue brief will include options for governance models and address standards for the Exchange governing body to include public accountability, transparency, and the prevention of conflict of interest.

To enable the establishment of a governance structure and board for a Kentucky Health Benefit Exchange, all options including legislation for introduction in the 2012 Regular Session of the General Assembly and Executive Order (EO) are being discussed and considered. If legislation is pursued, a bill may be drafted and shared with executive staff and policymakers as early as December 2011. Upon adoption and enrollment of this legislation, the effective date may be July 2012. If an Executive Order is determined to be a more appropriate option, no immediate legislation would be required and the effective date would be specified by the Governor.

Based upon the option selected, additional clarification of the legislation or EO may be necessary, in which case Kentucky Administrative Regulations for clarification will be drafted in July 2012, and complete the regulatory process by November 2012.

Program Integration

The Exchange Team will continue to meet weekly and collaborate on planning and development to ensure that all state agency stakeholders who own resources or processes necessary to the Exchange are engaged and involved in Exchange development. Regular meetings with Kentucky's Health Information Technology staff and the Department for Community Based Services will be initiated to develop work plans and collaborate on Exchange activity.

The state has developed a preliminary document (Attachment 3) indicating the functions currently performed by State Agencies, including DOI and DMS. As the work on the Exchange progresses, the Exchange Team will develop detailed business process documentation that reflects the state's current business processes and describes the future processes needed to support Exchange implementation.

The Office of Health Policy will formalize memorandum of agreements with both DMS and DOI with respect to roles and responsibilities of each agency for Exchange planning and development by August 31, 2011.

By September 2011, an internal work group for Medicaid and Insurance specific Exchange areas will be established. The Medicaid work group will analyze such areas as eligibility determinations, verification and enrollment; strategies for compliance with the "no wrong door" policy; benefits; Medicaid managed care; and IT systems, as well as other significant areas that may impact the Department for Medicaid Services and the Exchange. The insurance work group will analyze such areas as certification of qualified health plans; rate review; limiting adverse selection inside and outside the Exchange; development of risk adjustment process and reinsurance mechanism; market reforms inside and outside the Exchange, as well as other significant areas that may impact the DOI and the Exchange. These work groups will identify options and make recommendations relating to Medicaid, Insurance, and the Exchange, as well as define operating procedures between the Exchange and other state agencies. They will also develop a cost allocation methodology between the Exchange grant, DMS, and other funding streams and organizations.

Throughout the process of Exchange development, the Exchange Team will work to identify any challenges posed by program integration and develop strategies for mitigating these challenges.

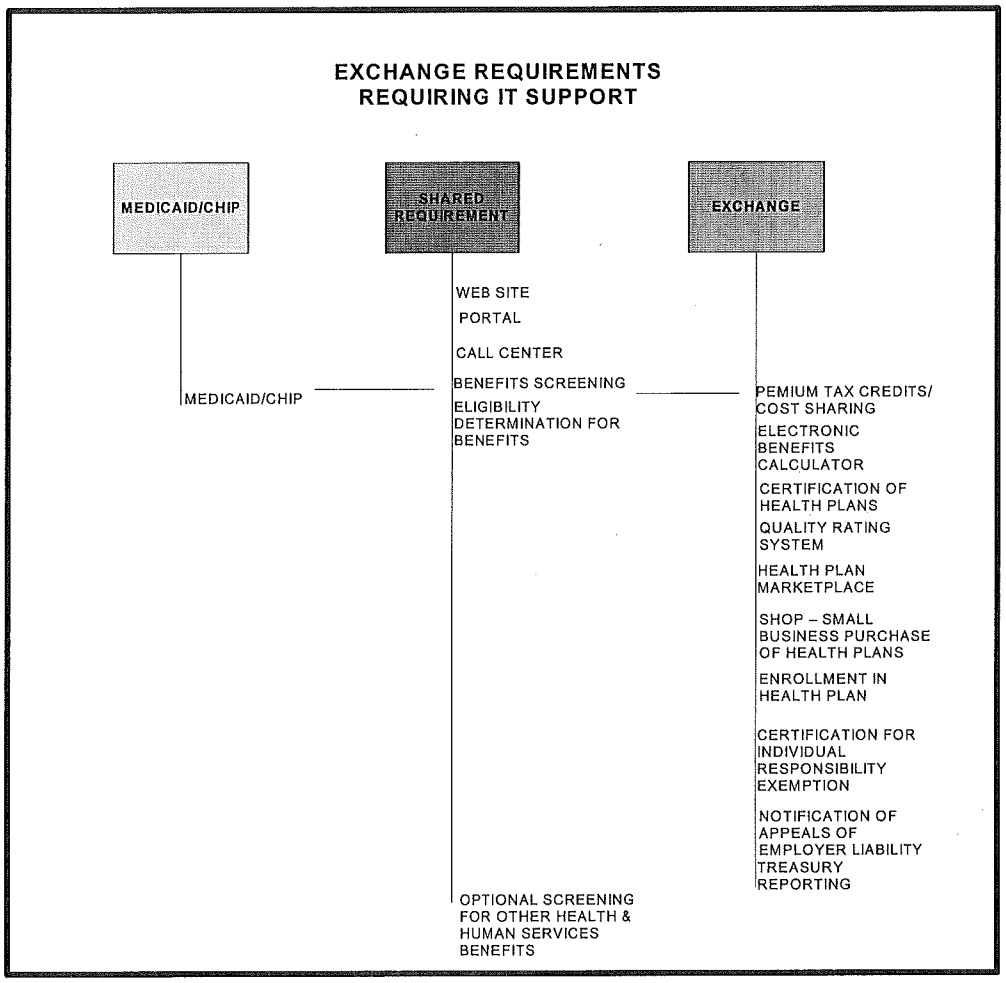
Through a consultant, Kentucky will also perform a high level analysis, create a flowchart of Exchange functions, and work collaboratively with DMS, DOI, OATS, and other state agencies, to identify current state business processes, and any necessary revisions to support proposed Exchange operational requirements.

Exchange IT Systems

To further advance the Exchange IT planning process, the Commonwealth proposes to secure the services of a highly competent IT contractor with expertise and direct experience in the health care industry and web-based marketing of health plan options, including rate setting, customer enrollment and an array of supports for enhanced customer service. The contractor would also have experience in IT eligibility and enrollment systems design as well as a history of collaboration with the federal government and states. The planning process would position the Commonwealth to leverage knowledge and resources that can be reused to minimize federal and state financial investment and maximize innovation and use of proven solutions. The addition of these resources would position the Commonwealth to meet the aggressive state and federal timeframes and milestones without compromising quality and cost and lead to certification in January 2013, operation and provision of health insurance coverage to enrollees in 2014, and self-sustainability in 2015.

As illustrated in following table, there are several core areas of the Exchange in which the IT functionality would be shared with Medicaid. This includes the web site and web portal.

Joint planning and design also would be required to operationalize the eligibility determination process for Medicaid and Exchange benefits (premium tax credits/cost sharing), which includes among other things, the development of a streamlined application to support eligibility determination for both programs. Because the intended business model is a single process under a coordinated set of rules with central adjudication for the entire population with modified adjusted gross income (MAGI) between 0-400% of the federal poverty level (FPL), the planning must occur jointly between the Exchange and the Department for Medicaid Services (DMS).



To assure coordination occurs between the Exchange and DMS, the planning contractor would support two parallel processes that intersect at routine intervals and support joint planning sessions for the requirements gathering and high-level IT design of these core areas.

The planning processes will follow a framework consistent with the Systems Development Life Cycle (SDLC) model that supports a series of step-by-step planning processes, milestones (mandatory federal and optional state-developed milestones), and deliverables that runs concurrently and intersects at pre-determined points with the Medicaid eligibility system planning process. The state-developed milestones will include a series of actions at pre-defined stages of the planning process that coincide with the mandatory milestones to assess and assure compliance with the applicable federal requirements and standards, as well as industry best practices.

Standards and Assurances. The Commonwealth is committed to a technology solution for the State Exchange that is interoperable and/or integrated or interfaced with the State Medicaid and Children's Health Insurance programs. The solution would interface with the Department of Health and Human Services in order to verify and acquire data as needed. The Commonwealth would ensure during the proposed design process that the steps necessary to achieve interoperability with other state health and human services programs will be addressed in the technology solution for purposes of coordinating eligibility determinations, referrals, verification or other functions.

The Commonwealth commits to a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces; the separation of business rules and machine readable programming; and the availability of business rules in both human and machine readable formats.

Information technology developed through the Establishment Grant and the enhanced Medicaid FFP would comply to the fullest extent possible with standards endorsed or adopted by the Secretary of Health and Human Services (HHS). To this end, the Exchange IT solution would comply with the HHS Joint Technical Standards, which are summarized in the table below:

JOINT TECHNICAL STANDARDS

5.1Standards: Interoperability, accessibility, and privacy and security	5.1.1	HIPAA Transaction Standards: Recommends using HIPAA adopted transaction standards to facilitate transfer of consumer eligibility, enrollment, and disenrollment information (e.g., ASC X12N 834, ASC x12N 270, ASC X12NS71)
	5.1.2	Additional Transaction Standards in the Affordable Care Act, including the National Information Exchange Model (NIEM) which provides a set of well-defined data elements using XML technology for data exchange development and harmonization to support document exchange across government
	5.1.3	Accessibility: Usability features or functions that accommodate the needs of persons with disabilities, including those who use assistive technology HHS will consider websites, interactive kiosks, and other IT systems addressed by Section 508 Standards as being in compliance with Section 504 if such technologies meet those standards States should take reasonable steps to provide meaningful access by persons with limited English proficiency
	5.1.4	Security and Privacy: Compliance with HIPPA Privacy and Security Rules IT systems containing tax return information must comply with the taxpayer privacy and safeguards requirements of Section 6103 of the Internal Revenue Code
	5.1.5	IT development projects should consider and apply NIST standards as appropriate
5.2 Architecture Guidance	5.2.1	System Integration: -Provide a high-level integration of process flow and information flow with such business partners as navigator, health plans, small businesses, brokers, employers, and others -Apply a modular, flexible approach to systems development, including the use of open interfaces and exposed application programming interfaces, and the separation of business rules from core programming, available in both human and machine-readable formats -Ensure seamless coordination between Medicaid, CHIP, and the Exchange, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services

	5.2.2	Service-Oriented Architecture: -Employ Web Services Architecture/Service-Oriented Architecture methodologies for system design and development -Employ common authoritative data sources and data exchange services, such as but not limited to, federal and state agencies or other commercial entities -Employ open architecture standards (non proprietary) for ease of information exchanges
	5.2.3	Isolation of Business Rules: -Use standards-based business rules and a technology-neutral business rule repository -Enable the business rules to be accessible and adaptable by other states
	5.2.4	Security and Privacy: Support the application of appropriate controls to provide security and protection of enrollee and patient privacy
	5.2.5	Efficient and Scalable Infrastructure: Leverage the concept of a shared pool of configurable, secure computing resources (e.g., cloud computing)
	5.2.6	Transparency, Accountability, and Evaluation: -Produce transaction data and reports in support of performance management, public transparency, policy analysis and program evaluation -Leverage Commercial Off-the-Shelf business intelligence functionality to support the development of new reports and respond to queries
	5.2.7	System Performance: -Ensure quality, integrity, accuracy, and usefulness of functionality and information -Provide timely information transaction processing, including maximizing real-time determinations and decisions -Ensure systems are highly available and respond in a timely manner to customer requests

The Commonwealth also would adhere to the Key Principles of Exchange IT capabilities as stated in Supplement D of the Establishment Grant Funding Opportunity Announcement:

- The organization governing the design, development, and implementation of the core capabilities would follow the SDLC framework, including the use of iterative and incremental development methodologies
- The Commonwealth would produce requirement specifications, analysis, design code, and testing that can be shared easily with other interested and authorized stakeholders
- The design would take advantage of a Web Services Architecture (using XML, SOAP and WSDL or REST) and Service Oriented Architecture approach for design and development leveraging the concepts of a shared pool of configurable computing resources, such as Cloud Computing
- The services description/definition, services interfaces, policies and business rules would be published in a web services registry to support both internal and external service requests that are public and private, and be able to manage role-based underlying data
- All designs would follow per ACA Section 1561, the standards that are currently outlined in the recommendations published by the Office of the National Coordination
- The design and implementation would take into account security standards and controls per the National Institute of Standards and Technology (NIST) publications

The key modules of the Commonwealth's Exchange IT system would include (but not be limited to): 1) Eligibility; 2) Enrollment; 3) Premium tax credits administration; 4) Cost-sharing assistance administration; 5) Health plan management to support Qualified Health Plan certification.

To meet the milestones and assure alignment with other critical State and Federal programs, the Commonwealth would leverage or re-use services or capabilities available in the State, including those offered by the State health information exchange to the extent possible and whenever feasible. (A list of potential shared services was identified as part of the Commonwealth's gap analysis, which is included as an attachment to this application.)

The Exchange IT solutions will conform to CMS Guidance for Exchange and Medicaid Information Technology Systems, Version 2.0 and future versions as they are issued. The Commonwealth also commits to the use of CMS Exchange Architecture Guidance and participation in collaborative design, and development efforts among federal and state Medicaid and exchange programs, including the Early Innovator grantees, to expedite development, meet aggressive federal milestones, and exercise stewardship of federal (and state) monies.

The Commonwealth would promote program evaluation through transaction data reports and performance information that contributes to program evaluation and continuous improvement in business operations, transparency, and accountability. The Exchange would support the use of reports that are automatically generated through open interfaces to designated federal repositories, with approved audit trails, as they become available.

Additionally, the Commonwealth intends to pursue a consumer-centric approach that would undergird the business, information, and technical design of the Exchange IT solution... This approach would account for the needs and preferences of the consumer and consider the functions, tools, and/or applications that are necessary to support consumers. To this end, the usability features recommended in a HHS whitepaper for eligibility and enrollment systems functionality would be applied to the extent possible to the system's design:

- Assisting the consumer in understanding their rights and meaningfully choosing among available options
- Guiding the consumer through screen-and-enroll processing in a reliable, accurate manner that supports efficient data entry in as close to real-time as possible
- Providing and soliciting information at appropriate literacy level that meets the language needs of the consumer
- Accommodating the needs of persons with disabilities, including those that use assistive technologies
- Allowing for storage of data—including documents and data supplied by the consumer, obtained from other sources, and/or inferred or derived from other data—for use in the renewal process
- Allowing the consumer to view, print, save, and export data in a format that can be used and reused by the consumer
- Facilitating the consumer to submit documentation where necessary (e.g., to demonstrate a change in circumstances)
- Enabling the consumer to use the system from multiple locations and over time without having to re-enter data or re-start the process
- Providing status updates to inform the consumer of where they are in the enrollment process and what, if any, action may be required to complete the process
- Providing a process whereby consumers can make inquiries to State personnel; resolve disputes regarding data inputs, verification and eligibility decisions; and, where necessary, formally appeal decisions
- Supporting a consumer's ability to obtain assistance from third parties such as family members, care givers, health care providers and community based organizations in their efforts to complete the application and renewal process
- Employing diverse modes of communication such as email, text messages, voicemail, etc. that reflect the individual consumer's needs and preferences

Procurement: To meet the rapidly approaching milestones, CHFS proposed to use an existing contract that CHFS has with a vendor for the Cabinet's eligibility system. To this end, the Commonwealth's Finance and Administration Cabinet has approved adding this scope of work to the contract.

The contractor has developed a total of 15 State Medicaid and cross-program eligibility systems. Furthermore, the contractor has previously performed an operational assessment for a State Health Insurance Exchange. In addition to the first-hand knowledge of Medicaid eligibility systems, the contractor has entered into a partnership with a highly reputable company that services the health insurance marketplace and provides a range of services including (but not limited to): web-based services, software as a service, and an array of marketplace solutions. This would bring the expertise and experience of a 21st century shopping experience to the State Exchange as well as actuarial and other industry experience that are required to operationalize and administer the Exchange.

The contractor's Exchange planning team would include consultants with direct experience in the health insurance industry and web-based marketing of health plan options, including rate setting, customer enrollment, and an array of supports for enhanced customer service. The contractor's Medicaid planning team would include individuals with Medicaid expertise and cross-program eligibility and enrollment systems.

The scope of work would commence on August 15, 2011, which is based on a 45-day expedited review of the Establishment Grant application and the PAPD, both of which will be submitted no later than June 30, 2011. The duration of the contract would run through June 15, 2012. At the conclusion of the Exchange systems planning process on December 31, 2011, the contractor would have assisted the Commonwealth in developing a:

- Plan that details recommendations for the operation and administration of the Exchange and the ways in which IT will be used to meet the needs of consumers and small businesses
- Description of each core area of the Exchange and how it will be rendered operational
- Preliminary set of functional requirements to support operations of each core area (including but not limited to): data requirements, data exchange, business rules, workflow engine, document management, documentation generation, data/information management, reporting, etc.
- Detailed set of business, technical architecture and information requirements
- Cost allocation methodology
- Security and risk assessment and release plan
- Identification and analysis of potential services that can shared with the Exchange (and other systems, such as KAMES)
- Potential "products" that can be leveraged from Early Innovator grantees and other states
- Complete set of preliminary detailed design and system requirements, including: system design, interoperability requirements and interfaces, data management and database design
- Assessment and written findings of preliminary detailed design and system design requirements against MITA, the Seven Standards and Conditions for Enhanced FFP, CMS/CCIIO Joint Guidance, etc. to ensure full compliance
- An enterprise wide roadmap for development of the IT solutions for the State Exchange and Medicaid eligibility and enrollment
- Estimated costs and cost allocation for Exchange systems design and development

The contract would continue through June 15, 2012 during which time the planning contractor would assist the Commonwealth in developing a:

- RFP for the services of a contractor by January 31, 2012 to complete the detailed design, development, and implementation of the system in the event that the decision is made to procure the services of a new contractor
- Level II Establishment Grant application for submission on March 31, 2012 (in the event that governance authority has not been finalized, a Level I Establishment Grant will be submitted)

- A preliminary baseline system and review to ensure compliance with business and design requirements completed by March 31, 2012; an interim review completed by June 15, 2012

Project Management and Staffing. The Commonwealth has a sound organizational structure and management plan to oversee the development of the scope of work. Executive leadership for the proposed planning process would be provided by Carrie Banahan, the Executive Director of the OHP and lead for the State Exchange. Of relevance to the project, Ms. Banahan previously served as Deputy Commissioner of DMS and as a Director in the DOI responsible for health insurance. Kathy Frye, OATS Deputy Executive Director/CIO, and Sandeep Kapoor, OATS Chief Technical Architect, would also serve on the executive leadership team and oversee implementation of the technical scope of work. Programmatic oversight would be provided by Ms. Banahan. Additional executive level expertise will be supplied on an as-needed basis by the DMS Commissioner, the OATS Executive Director, and the Cabinet's chief budget officer. All executive level staff is under the direction of CHFS Secretary, Janie Miller. Secretary Miller has previously served as Commissioner of the State Department of Insurance and Medicaid Commissioner.

Responsibility for the day-to-day activities required to perform the scope of work, including contractor oversight, would be carried out by the OATS Benefits Exchange IT Project Team. To support coordination, the Benefits Exchange and Medicaid IT planning teams are co-located in a project management unit within the Division of Systems Management. The composition of the Benefits Exchange IT planning team is as follows: Project Manager (1 FTE); Technical Architect (2.0 FTE); Business Analyst (3.0 FTE); Reporting/Auditing Specialist (1 FTE); Subject Matter Expert (1 FTE), .Net Developer (2.0 FTE), and Contracts Manager (1.0 FTE). Each of the business analysts will be assigned to a major area of operation and serve as project liaison to the stakeholder groups that would "own" the process: DMS (Medicaid/CHIP); DOI (health plans); and OHP (the Exchange).

The project manager would monitor performance, identify and mitigate risks, and take the necessary steps to assure that the project leads to Exchange certification in January 2013, operation and provision of health insurance coverage to enrollees in 2014. The contracts project manager would provide monthly analysis and documentation of the planning contractor's performance against the mandatory milestones and a detailed project plan; and, monitor IT related grant expenditures to ensure the project is completed within budget and to prevent waste, fraud, and abuse.

The robust team would support the planning process and continue throughout the development and implementation of the Exchange IT system. The overarching goal for the team would be to develop a sound understanding and the institutional knowledge of the business processes, information exchange requirements, technology requirements (including integration and interoperability issues), and preliminary design to manage and oversee the work of the contractor tasked with systems design and development. In the event that the Exchange remains in CHFS after governance is determined, the Exchange IT Project Team would continue to provide support and maintain the IT solution over the system's lifetime.

In addition to the Exchange IT project team and the planning contractor, a team of internal experts would be assembled to participate in and/or serve as subject matter experts during the planning process. Subject matter experts and operational staff from OHP, OATS, DOI, DMS and other stakeholders would participate on an as-needed basis throughout the planning process to provide specialized input and expertise.

The expertise and experience of the executive leadership team coupled with the veteran IT project team would ensure that the scope of work is completed within schedule and budget. The capacity of OATS leadership and staff to innovate and deliver high quality technical solutions is evidenced in the implementation of quality solutions, including:

- Implementation of the Kentucky Medicaid Electronic Health Record (EHR) Incentive Program in January 2011. Kentucky was among the first four states in the nation to begin receiving federal dollars under the

Medicaid EHR program. Two Kentucky hospitals were the first hospitals in the country to receive payments.

- Development of the Kentucky Health Information Exchange (KHIE). The KHIE, which was developed with a Medicaid Transformation Grant, provides the technical infrastructure to support statewide health information exchange. The KHIE, which went live on April 1, 2010, is one of the few operating state health information exchanges. Under a collaborative arrangement with the Governor's Office of Electronic Health Information (GOEHI), OATS is responsible for the technology and GOEHI is responsible for the programmatic aspects of the KHIE. In April 2011, the KHIE received a Best of Kentucky award from the Commonwealth Office of Technology for Best IT Collaboration among Organizations.
- Development of the Vulnerability Assessment Integration with the Software Development Life Cycle Program, which was designed to ensure that citizen information remains private when accessed via electronic methods, including web based applications. OATS also received a Best of Kentucky Award for the Best Risk Management Initiative in April 2011.

Participation in Collaborative Development and Intent to Leverage Existing Design and Development. The Commonwealth is fortunate in that the state health information exchange program is located in the CHFS. Moreover, OATS is charged with responsibility for the technology that supports the Kentucky Health Information Exchange (KHIE). The expertise and experience gained through the development of the KHIE, which went live on April 10, 2010, would be leveraged throughout the development of the State Health Benefit Exchange. As the Exchange is designed and developed, the opportunity to share services would be explored.

The Commonwealth would carry out due diligence in assessing the applicability of the system models and technology solutions developed by the Early Innovator state grantees. Additionally, it plans to leverage to the fullest extent the expertise and experience of CMS, other states, and industry (including the use of commercial off the shelf products) to support development of the State Exchange and the Medicaid eligibility and enrollment system.

To-date, the Commonwealth has participated in a number of conferences, workshops, and vendor presentations to explore the range of options available for use in developing the State Exchange. This has included a number of demonstrations of existing technology and prototypes of web-based health insurance marketplaces and eligibility systems. Staff have reviewed Early Innovator State approaches and discussed approaches under development by other states. Travel funds are included in the budget to allow state to travel to selected states and attend national meetings to learn more about the technology that is under development. The Commonwealth also has indicated its intent to CCIIO to participate in the ALM.

Of note, the Commonwealth has assumed a leadership role and is providing staff support to the Region IV Medicaid South East Regional Collaborative for HIT (SERCH) to support collaboration across states during the development of technology solutions to support implementation of the ACA. This collaboration is critical during the planning phase as the Region IV States share many attributes that will impact design and operation of the Exchanges, including high poverty rates among adults, high rates of the uninsured, and the challenges of service delivery in rural geographically isolated areas balanced with the needs of densely populated urban centers.

Project Workplan. A SDLC project plan for the period through January 1, 2014 is included as an attachment. The project plan will be used by the project managers to ensure that the project is on schedule, within budget, and that advance planning occurs throughout the process to ensure that federal milestones and gate reviews are met and that certification is achieved in January 2013 leading to the operation and provision of health insurance coverage to enrollees in 2014. It includes the start and end date that is proposed for each activity.

The following table lists state milestones and federal milestones consistent with the SDLC framework for the IT Core Component. Information technology is a component of many business functions of the Exchange, including those set forth in Section 1311(d)(4) as well as the requirements in Sections 1411, 1412 and 1413 related to eligibility and enrollment. The work plan for this Core Area encompasses the performance of the Exchange in planning for and establishing these systems in the various functional areas.

Milestones for the period from August 15, 2011 through August 14, 2012 reflect the scope of work to be accomplished under the proposed Level I Establishment Grant. Although the federal milestones were first released in the Establishment Grant FOA issued by CCIIO in January 2011, several state milestones were initiated earlier with the start of the Planning Grant and reflect work done prior to January 2011. These milestones are included in the table due to the iterative nature of the planning process in which the actions will be ongoing and the deliverables refined through August 14, 2012 in conjunction with the scope of work.

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
Develop an ACA State Exchange/Medicaid Project Management Unit in which state staff assigned to the development of the IT solutions are housed together in OATS to support collaboration & joint planning Set up a SharePoint Site for OHP, Medicaid, OATS, and DOI project staff to access & share information (completed 11/10) Planning Grant	First project manager hired in November 2010; second project manager hired in May 2011 Planning Grant to be transitioned to Establishment Grant 8/15/11 Additional staff are being requested to form 2 teams: one focusing on the Medicaid eligibility system; the other on the State Exchange IT infrastructure Staff to be hired & on-board by 8/15/11 Establishment Grant	Conduct a gap analysis & Complete the review of product feasibility, viability, and alignment with Exchange program goals & objectives Planning Grant	Draft completed by 3/31//11 by the Project Management Unit
Conduct background research to include: -Internet search & screen shops of web-based eligibility systems -Contractor presentations -State & contractor presentations of existing & prototype web-based eligibility systems & health insurance marketplaces & COTS products	Initiated October 2010; ongoing	Conduct preliminary business requirements & develop an IT architectural and integration framework Planning Grant	Draft completed by 3/31/11 as part of the Gap Analysis

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
-Participation in CCIIO, CMS & other conference calls, workshops, conference -Review & written summary of Early Innovator grant applications prepared & attached to Gap Analysis Planning Grant			
Support cross-state collaboration & leverage design & development work by other states -SERCH - Attendance at national meetings -Participation in National Calls -Participation in the ALM Planning Grant through 8/14/11; thereafter, Establishment Grant	Initiated September 2010; ongoing	Begin developing requirements, including: -Integrating or interfacing the Exchange & Medicaid/CHIP to support enrollment transactions & eligibility referrals -Coordinate appeals -Coordinate applications & notices -Manage transitions -Communicate the enrollment status of individuals Establishment Grant	Initiated in conjunction with the gap analysis/ business requirements gathering at a high level; to be ongoing with preliminary requirements completed in collaboration with the Medicaid IT Team by 12/31/11
Develop a description of each core area of the Exchange and how it will be rendered operational to include a preliminary set of functional requirements to support operations of each core area	Planning contractor will lead development of the written descriptions that will be used to inform the development of the preliminary detailed design & systems requirements by 9/30/11(a federal milestone)* Establishment Grant	Begin developing requirements for systems & program operations for the enrollment process including: -Provision of customized plan information to individuals based on eligibility & QHP data; -Submission of enrollment transactions to QHP issuers;	- To be lead by Planning contractor in conjunction with the description of each core area of the Exchange with findings used to develop the Document preliminary detailed design & systems requirements by 9/30/11

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
		-Receipt of acknowledgements of enrollment transactions from QHP issuers; -Submission of relevant data to HHS Establishment Grant	
		Begin developing requirements for systems & program operations, including: -Exchange website & Calculator -Quality rating system -Enrollment process -Exemption from Individual Responsibility Requirement & Payment -Premium Tax Credit & Cost-Sharing Reduction -Notification of appeals of employer liability for the employer responsibility payment -Information & reporting to IRS Establishment Grant	- To be lead by Planning contractor in conjunction with the description of each core area of the Exchange with findings used to develop the Document preliminary detailed design & systems requirements by 9/30/11
Development of an enterprise wide strategic plan/roadmap to guide development of Exchange & Medicaid EE Systems IT through the services of a contractor who will design & implement	Procurement strategy developed 6/11; Scope of work developed 6/11; Contractor selection & contract modification to occur during 7/11;	Complete Systems Development Life Cycle implementation plan Draft to be completed by 6/30/11 by the	Draft to be completed by 6/30/11 by the Project Management Unit; it will be revisited during the planning process and finalized in

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
parallel planning process that will run from 8/15/11-12/31/11 Establishment Grant	Start date 8/15/11 through 6/14/12 Developed under Planning Grant	Project Management Unit Planning Grant	collaboration with the Medicaid IT Team by 12/31/11
Development of a business plan that details recommendations for operation & administration of the Exchange & explores sustainability options	Planning Contractor by 12/1/11 (Will complement IT roadmap)	Develop a Security Risk Assessment Plan Establishment Grant	The planning contractor will develop a written plan by 9/30/11
Assess the degree of compliance (or implications for/impact on compliance) & specify corrective measures for each set of documentation that is produced, including business rules; business, technical, & information architecture, etc. (The IAPD & RFP produced at the end of the planning process will also be assessed for compliance) Compliance will be assessed for: Adherence to SDLC framework; MITA; CMS 7 Standards & Conditions for Enhanced FFP; CMS/CCIIO Joint Technical Guidance; CMS Guidance for Exchange & Medicaid IT Systems; Assurances listed in Section 6 of this PAPD; Federal Exchange Architecture Guidance; etc.	Project manager and core team with the assistance of the Planning contractor; to be done within 10 days from the product/deliverable's submission by the contractor	Document preliminary detailed design & systems requirements* Establishment Grant	The planning contractor will develop by 9/30/11
		Develop the IT integration architecture; final business rules & requirements; & interim detailed design & system requirements documentation Establishment Grant	The planning contractor will develop by 12/31/11

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
OATS will assure the identification of industry standards, the incorporation of the standards in the requirements gathering processes that will be undertaken with this project. Establishment Grant		Begin developing requirements for the Exchange website & linkages to other health & human services as appropriate Establishment Grant	Initiated in conjunction with the gap analysis/ business requirements gathering at a high level; to be ongoing with preliminary requirements developed in collaboration with the Medicaid IT Team by 12/31/11
		Perform detailed business process documentation to reflect current State business processes, & include future State process changes to support proposed Exchange operational requirements Establishment Grant	To be developed by the planning contractor by 12/31/11
		Hold collaboration meetings to develop work plans for collaboration among state stakeholders Planning Grant transition to Establishment Grant on 8/15/11	Underway & ongoing-convened weekly by the OHP
		Execute agreement between the Exchange (OHP) and DMS that includes: -Roles & responsibilities related to eligibility determination, verification &	Under the leadership of the OHP, the Agreement to be developed & signed June 30, 2011 Ongoing planning process and joint sessions between the Exchange Planning

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
		enrollment -Identification of challenges in the program integration process, strategies for mitigating those issues, & timelines for completion -Strategies for compliance with "no wrong door" policy -Cost allocation between the Exchange grants, Medicaid FFP, and other funds streams as appropriate Planning Grant transition to Establishment Grant 8/15/11	Team & the Medicaid Eligibility & Enrollment Team will facilitate continuing identification of the issues and development of strategies, etc. to address/mitigate throughout the planning process Development of cost allocation has been identified in the scope of work for the planning contractor with a draft allocation plan ready by 9/30/11 & finalized during development of the Establishment Grant & IAPD budget by 12/31/11
		Optional federal milestone: Collaboration between OHP & DMS on procurement and development of Exchange & Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations Establishment Grant	Contractor will assist CHFS/both teams in developing Establishment Grant for Exchange IT submission on 3/31/12 and IAPD by 12/31/11& RFP for Medicaid System to be developed by 1/31/12
		Complete final requirements documentation (including system design, interface control, data	Planning contractor will complete by March 31, 2012

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
		management & database design Establishment Grant	
		Begin systems development on the: -Exchange Website & Calculator -Quality Rating System -Plan Enrollment Process -Applications & Notices -Exemptions from Individual Responsibility Requirement & Payment -Premium Tax Credit & Cost-Sharing Reduction Administration -Notification & Appeals of employer liability for the employer responsibility payment -Information reporting to IRS and enrollee -Other systems requirements for the SHOP Establishment Grant	In the event that the planning contractor is retained for Exchange development, systems development will begin by March 31, 2012 –otherwise it will begin in the 2nd quarter of 2012
		Preliminary and interim development of baseline system and review to ensure compliance with business and design requirements is completed	Preliminary completed by March 31, 2012 Interim completed by June 14, 2012 by the Planning Contractor

State and Federal Milestones & Workplan State Health Benefit Exchange IT For the Period from September 1, 2010 – August 14, 2012			
State Established Milestone	***Period of Performance***	***Federal Milestone***	***Period of Performance***
		Establishment Grant	

Financial Management

As part of the overall operational plan and focus of the Level One Funding request, Kentucky will assess resources, needs, and gaps to develop a financial management structure for the Exchange. Current state government system of accounting (known as eMARS) will be explored for use by the Exchange. By using the accounting system currently in place, the Exchange will have the advantage of a chart of accounts that is operational and functioning, with a comprehensive set of automated internal controls. Given that the Exchange may utilize eMARS, a large part of the internal controls are already inherent within the system. Because of the extent of existing internal controls, additional analysis may only be necessary to include those integral functions of the Exchange. Kentucky will also review the current system to determine how to accommodate accounting/financial transactions between the Exchange and insurers.

Kentucky will begin defining the financial management structure and scope of activities required to comply with ACA requirements. A financial model will be developed that will project exchange revenue and expenses over 5 years, recommend levels of funding required to make the exchange self-sustaining by January 2015, and compute the estimated resources required for the first 5 years of operation. This plan will ensure that sufficient resources are available to support ongoing operations.

Once these functions are complete, Kentucky will commit to hiring experienced accountants to support financial management activities of the Exchange, which will include responding to audit requests and inquiries of the Secretary and the Government Accountability office, as needed. At the completion of the design of the financial management system, the system will be transitioned over to the Exchange entity for implementation.

Kentucky will continue to adhere to all financial monitoring activities required for the use of federal grant funds.

Program Integrity

The program integrity function will address prevention of waste, fraud, and abuse. As part of the overall operational plan and focus of Level One Funding, Kentucky will develop a program integrity plan for the Exchange. Existing program integrity programs will be assessed, plan processes will be developed, and a hiring plan will be created. Medicaid program integrity functions will be reviewed and analyzed to determine whether any may be adequate and appropriate for use by the Exchange, and to avoid duplication of services. Current existing systems, including but not limited to, Medicaid Management Information System (MMIS) and eMARS (the Commonwealth's accounting and reporting system), will be reviewed for internal operating security protocols. Other operating systems will be identified and reviewed as appropriate.

Health Insurance Market Reforms

To conform Kentucky's insurance laws to the federal requirements and provide state-based authority to enforce the implementation of market reforms, all options including legislation for introduction in the 2012 Regular Session of the General Assembly are being discussed and considered. If legislation is pursued, a bill may be

drafted and shared with executive staff and policymakers as early as December 2011. Upon adoption and enrollment of this legislation, the effective date will be July 2012.

If additional clarification of the legislation is necessary, Kentucky Administrative Regulations for clarification will be drafted in July 2012, and complete the regulatory process by November 2012.

Providing Assistance to Individuals and Small Business, Coverage Appeals, and Complaints

Kentucky will determine the best methods to assure that the following services are available and sufficient to meet State residents' need for assistance:

1. Help individuals determine eligibility for private and public coverage and enroll in such coverage;
2. Help file grievances and appeals;
3. Provide information about consumer protections;
4. Collect data on inquires, problems and resolutions; and
5. Maintain database, appropriate records, and data associated with consumer assistance activities.

As part of the operational plan a determination will be made whether these functions will operate within the Exchange, what protocols will be necessary, and how information will be collected and transferred as well as the capacity to handle the coverage appeal functions. Policies and procedures will also be established for appeals of coverage determinations, including review standards, timelines, and provisions for consumers during the appeals process.

The Department of Insurance (DOI) has been awarded the rate review grant and the consumer assistance grant. Under the rate review grant, Kentucky has begun the process of making improvements to handling constituent inquiries, external reviews and appeals protocols for denials of coverage. Also, DOI will develop an online portal to for public access to filings and rate changes as well as an online portal for reporting fraud. Kentucky anticipates that this process will educate and make rate information available to Kentucky health insurance consumers.

Additional Level One funding will allow Kentucky to continue the KHIA program designed to assist and educate consumers and businesses of the Commonwealth with regard to health insurance coverage, access, and appeals. The program has begun their initial goal of outreach and education through television and radio public service announcements launched earlier this month. Also, to provide a point of contact for consumer questions, the KHIA hotline phone number will be printed on all Explanations of Benefit statements starting July 1, 2011 for fully-insured and self-funded health insurance plans. Continuation of this program will allow Kentucky to capture more detailed information about the adversities faced by its citizens regarding health insurance access, affordability, and coverage issues.

The KHIA database, currently used to capture complaint information, will be enhanced to allow the KHIA staff to capture additional data elements including the type of assistance necessary (e.g., billing, appeals, enrollment), and any necessary agency or program referrals (e.g., Medicaid, CHIP, Exchange upon implementation). Captured data will be analyzed to assist the state with: continued public education regarding insurance options; the development of an education and outreach program; evaluating current call center systems interoperability; and upon Exchange implementation, reporting on QHP accountability and Exchange functions.

Business Operations/Exchange Functions

Kentucky's focus for Level One funding will be to assist in defining and developing required business operations and Exchange functions. As noted in the Program Integration section, Kentucky will perform an initial high level analysis and create a roadmap (flowchart) of Exchange functions. Once these operations and functions have been identified, the Exchange Team will collaborate with DMS, DOI, OATS, and other state agencies, to identify

current state business processes and integrate future state process changes to support operational requirements. Mapping and flowcharting necessary Exchange functions will not only assist with program integration, but will also help Kentucky determine the fiscal impact of each business function, and facilitate an analysis of costs and resources required to sustain the Exchange. Ongoing analysis of business operations and Exchange functions will follow and also include staffing, budget, and other identified needs.

Kentucky has identified high level required business operations and Exchange functions identified in the table below and anticipates using a contractor to assist with the process of defining the detailed business operations of the Exchange. Steps necessary to procure a contractor are being initiated. The contractor will be required to develop process descriptions and standard operating procedures, as well as define roles and responsibilities, key activity steps, inputs, outputs, and staffing requirements. In the process of this development, the contractor will also be required to identify and document outstanding issues, questions, and options that require assessment and/or policy decisions before implementing the Exchange. Finally, detailed business operations and Exchange functions will be defined at a level sufficient to support and enable the development of technical requirements and support solutions.

Business Functions	18 Business Operations/Exchange Functions
• Web Portal • Screening & Eligibility • Enrollment Management	• Exchange Website • Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid • Individual responsibility determinations • Enrollment process • Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
• Premium tax credit and cost-sharing management • Plan Management	• Premium tax credit and cost sharing reduction calculator • Administration of premium tax credits and cost-sharing reductions • Certification, recertification, and decertification of qualified health plans
• Outreach and Marketing • Employer Relations • Consumer Assistance Ombudsman	• Navigator program • Outreach & education • Call center • Applications and Notices • Adjudication of appeals of eligibility determinations • Notification and appeals of employer liability • SHOP Exchange –specific functions
• Risk Adjustment • Program Finances	• Risk adjustment and transitional reinsurance
• Reporting & Evaluation • State & Federal	• Quality Rating System • Information reporting to IRS and enrollees

Summary of Exchange IT Gap Analysis

The ACA stipulates that states electing to develop a State Exchange must demonstrate to the Secretary of HHS by 2013 they will have the existing capacity to have an operational Exchange by January 2014. However, although not specified in the ACA legislation, the Exchange actually has to be operational by October 2013 to support an open-enrollment process as the individual responsibility requirement goes into effect on January 1, 2014. The

Commonwealth does not have an operating Health Benefit Exchange nor does it have an existing technology infrastructure that could be rapidly deployed to support a web-based solution that integrates the multiple aspects of health insurance enrollment and administration of financial services, including federal cost subsidies.

Eligibility for the State Medicaid and CHIP programs is determined the Department for Community Based Services (DCBS), which is an administrative unit of the CHFS. DMS has entered into an interagency agreement with DCBS for eligibility determination, enrollment, and recertification of Medicaid and CHIP members, except for Supplemental Security Income recipients for whom Medicaid eligibility is determined pursuant to an agreement with the Social Security Administration. DCBS, which serves as the single State agency for financial assistance under Title IV-A, maintains local offices in each of Kentucky's 120 counties.

Although applicants for Medicaid and CHIP can access eligibility applications on-line, the applications cannot be completed on-line or returned to DCBS electronically. A combined application for Medicaid/CHIP/and K-TAP (transitional income assistance) can be printed and returned to the DCBS at which time a caseworker will schedule a face-to-face interview to complete the process. Another application specifically for CHIP can be obtained on-line, completed and returned to DCBS. Applicants applying only for CHIP are not required to have a face-to-face interview with DCBS. Kentucky does not offer the "Express Lane Eligibility" option to enroll eligible children in Medicaid/CHIP.

Eligibility and enrollment in Medicaid/CHIP and the state's other income maintenance programs (including SNAP) is done through the Kentucky Automated Management and Eligibility System (KAMES). KAMES is a 17-year-old legacy system that fully integrates eligibility determination and redetermination for the State's income maintenance programs, SNAP, and Medicaid/CHIP. The system handles an average of 2 million transactions per day, supports over 3900 users statewide, and provides an average response time of less than one second. It interfaces with numerous systems both online and through batch cycles, supports system matches, and retrieves customer data to auto-populate forms and compute and verify eligibility. KAMES is supported by multiple security platforms to protect personal information, limit access, and guard against fraud and abuse.

In spite of the system's competence, the existing KAMES platform does not support simplified eligibility, including web-based application and enrollment processes, and the consumer-centric usability features specified by HHS for determining Medicaid/CHIP eligibility. Nor does it align with the information technology framework specified by HHS, which calls for a distributive architecture and coordination of shared services supported by newer technologies as opposed to a legacy environment.

KAMES cannot meet the IT architectural standards and support the core functionality required by the State Exchange. The information technology solution that supports the State Benefits Exchange requires capability to determine eligibility for and administer health benefits beyond Medicaid and CHIP, both of which are currently supported by KAMES. This includes the determination of eligibility for and administration of premium tax credits and cost-sharing benefits. It must support presentation of qualified health plan options, a consumer toolset, including a benefits calculator; and, consumer enrollment in the health plans. It requires functionality to support billing and payments; meet federal reporting requirements; and support customers with changes in income (the legislation cites a 20 percent change in income as the threshold) and other changes that may result in shifts in eligibility from one Exchange benefit to another.

Moreover, in pursing upgrades to the Medicaid Management Information System (MMIS), DMS has decided to upgrade and integrate the eligibility and enrollment system with the MMIS. This would result in increased business capability in member management and a higher maturity level for the Medicaid Information Technology Architecture (MITA). The new eligibility system would accommodate new eligibility rules proposed by the ACA, be compliant with the seven standards and conditions for Medicaid eligibility systems design and development specified by CMS as a condition for enhanced funding and, be compatible with the claims processing and information retrieval systems utilized in the administration of the Medicaid program. The modular platform

would allow applicants to self register and apply for Medicaid benefits on-line. It would provide automatic verification of applicant information through seamless electronic exchanges with other state and federal sources and provide for real time determination of applicant eligibility. Seamless integration with the MMIS would further support improvements in timely and effective processing of claims.

The new Medicaid eligibility system would be designed to accommodate future eligibility changes with greater ease, ensure seamless coordination and integration with the State Health Benefit Exchange, and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.
In designing the Medicaid and Exchange IT solutions, the gap analysis determined that many of the required functionalities for the Exchange's benefits programs would cross programs. This would provide the opportunity in the technical and business framework to share services across platforms, streamline and integrate service delivery, and reduce development costs. At some point, the master patient index functionality and the provider directory functionalities of the State health information exchange also may be shared cross-systems.

Shared Functionality—Based on Expected Requirements

Required Functionality	***KAMES- Income Maintenance/ SNAP****	***Medicaid /CHIP***	***Individual Market***	***Group Market***
Help function	X	X	X	X
Integration with KEUPS to include the ability to maintain user accounts, passwords & profiles	X	X	X	X
User identity verification	X	X	X	X
A single intuitive simplified application	X	X	X	
Electronic signatures	X	X	X	X
Master Customer Index	X	X	X	
Data matching	X	X	X	
Auto-fill for the application	X	X	X	X
Screening for benefits eligibility supported by a rules based eligibility engine	X	X	X	
Rules-based/dated eligibility tables/databases	X	X	X	
Electronic verification	X	X	X	
Eligibility determination		X	X	
Determination of benefit(s) level		X	X	X
Health plan options (3 levels for both markets)			X	X
Benefits calculator for use by the customer			X	X
Health plan enrollment			X	X
Selection of a medical home/MCO (KenPAC, etc.)/ provider directory		X	X	X
Information required by the selected health plan			X	X
Request for information notice	X	X	X	X
Capacity to do billing and process premium payments through the State's e-Payment Gateway			X	X
Benefits coordination across programs	X	X	X	
Notice of benefits	X	X	X	X
Mechanism to enter changes	X	X	X	X
Recertification	X	X	X	X
Assignment to DCBS, other (call center, etc.)	X	X	X	X

Required Functionality	*KAMES- Income Maintenance/ SNAP**	*Medicaid /CHIP*	*Individual Market*	*Group Market*
Query functionality	X	X	X	X

*Refers to functionality currently in-place or to be developed in conjunction with KAMES modernization during 2012-2014

During the gap analysis, a number of the issues were identified that must be addressed and decisions made in order to drive development of the Exchange IT solution, including (but not limited to):

- The user experience that customers want and the ways in which access will be simplified and streamlined
- Extent to which the state will administer the QHP enrollment plans, for example:
  - Administer enrollment, collect premiums (note: premiums in the individual market are typically pre-paid), etc.
  - Re-direct applicant to the health plan's website
  - Outsource all insurance exchange functions to a 3rd party administrator
- Roles and responsibilities of all parties in the Exchange and the technology to support required systems interfaces and integrated operations
- Business services/functionality required to support navigators, brokers, other community partners who will support enrollment
- Existing business services/functionality that can be leveraged
- Identity matching/verification
- Hosting of the Exchange: SOA, in-house, cloud computing, other
- Standardization of health plan information to afford comparability through the Exchange
- Administration and operation of call-centers, etc and development of technology to support these functions
- Procurement, including coordination with other related CHFS IT systems development (e.g., MMIS, etc.)
- Consideration of existing models and services that can be leveraged from other industries:
  - Medicare Part D and Advantage Care on-line enrollment brokers
  - Financial services (banking)
- Differences in eligibility determination requirements for expanded Medicaid and traditional categorically based Medicaid
- Migration of Medicaid eligibility system from KAMES
- Interface(s) with KAMES and its related systems and the impact on eligibility determination for other state income maintenance programs
- Management of "churn" to minimize disruptions in care—participants with changes in eligibility and enrollment who will transfer from Medicaid to other Exchange benefits and vice versa
- Timeframes, including timely access to systems design and applications developed by Early Innovator states

The gap analysis also identified four viable models of implementation (which are consistent with the literature and approaches being used by the Early Innovator States) that can serve as a guide during the design process:

1. Single Front Door Process: Single entry portal with integrated back end systems
2. Two Path Process with two back end systems: Customer chooses which path to pursue: public benefit programs or health insurance enrollment (there is some integration between systems but also duplication); this approach generally appeals to state insurance departments
3. No Wrong Door: System has two public facing portals (public benefit programs & health insurance enrollment); guides user down proper path, leverages common functions; uses single integrated back end system; this approach generally most appealing to health & human services agencies

4. Software as a Service: Use of an existing software package, such as those developed, maintained, and hosted by a the vendor for commercial health insurance exchanges and one-stop integrated health and human services eligibility systems

The selected model must be compatible with the state's goals, priority services and populations and preferences/needs of the stakeholders/partners. This information, in turn, would provide the focus and delineate the priorities that would drive the incremental development of the State Exchange.
Other considerations identified that could impact selection of the Exchange model include (but are not limited to):

- DMS's intent to build a new Medicaid eligibility system that will be part of the MMIS.
- The development of the separate Medicaid eligibility system will substantially reduce the Cabinet's burden in determining cost allocation.
- Governance for the KHBE has not been determined (one scenario would be the establishment of a quasi government agency such as the Public Service Commission to oversee the Exchange); consequently ownership and operational responsibility for the Exchange could be transferred at a later date from CHFS to another entity.
- Interoperability and development of interfaces to support bi-directional exchange is critical between the KHBE, Medicaid eligibility system, KAMES, other related systems (including databases and tables), and the HHS verification hub that is slated to be built; delineation of high level requirements and business processes, including acquisition and transfer of data elements, location of data elements, matching processes, translation, etc.
- Likely degree of eligibility "churn" necessitates strong demand for seamless transition between the Medicaid and insurance sides when eligibility shifts among individuals and families from Medicaid/CHIP to eligibility for premium tax credits/cost sharing and vice versa should be considered when building the public facing Web portal(s).
- Although a decision has not yet been made regarding how selection, enrollment, and premiums will be paid for the qualified health plans in the individual and group market, there is sufficient information regarding the premium tax credits/cost sharing programs to pursue a high level design that includes identification of interfaces and data transfer points with KAMES and the proposed Medicaid eligibility system.
- The Establishment Grant FOA requires stakeholder participation and identification of consumer preferences, both of which could influence whether there is a single or double facing web portal, etc.
- The decision to build a new Medicaid eligibility system and the need for portability suggest that the design include two or more separate but integrated back end systems instead of a single integrated back end system.

Based on findings from the gap analysis, including the need to address a number of business decisions before proceeding with the IT solution design, the Commonwealth determined that further planning and the expertise of a contractor with experience in the design and development of web-based eligibility systems and web-based insurance marketplaces would be the appropriate course of action. To this end, the Commonwealth would submit a Level I Establishment Grant to focus on business development and IT solution design. A concurrent planning process would be undertaken leading to the design and development of a Medicaid eligibility system.

Evaluation Plan

Kentucky will use a defined project management methodology tool to evaluate progress, measure performance, and ensure success in each of the Exchange core areas. The Project Manager will monitor and evaluate progress in each core area to ensure that the Level One funding deliverables are provided in a timely manner and within budget, and that sufficient organizational structure, work plans, processes and reporting tools are present to identify and escalate issues to the appropriate level, as needed.

The evaluation plan presented in this application includes the following:

- Key indicators to be measured
- Baseline data for each indicator
- Methods and their efficacy to monitor progress and evaluate the achievement of program goals
- Inclusion of plans for corrective action or timely interventions if targets are not met or unexpected obstacles delay plans
- Inclusion of a plan for ongoing evaluation of Exchange functions following Exchange implementation

Any contractor will report directly to the Project Manager and Exchange team on a monthly basis or more frequently, if necessary and requested by the Project Manager.

Key Indicators to be Measured

The Work Plan and Timeline, included in this application, identifies the principal tasks and timelines for achievement/completion of milestones within each Core Area during the Level One funding period. These tasks and milestones are the project's key indicators to be measured. Progress toward the completion/achievement of task/milestones will be monitored on an ongoing basis by reviewing weekly and monthly management reports. CCIIO will be provided a report of this progress through routine Quarterly Reports or more frequently, if requested by CCIIO.

Baseline Data for Each Indicator

Baseline data for each principal project task and milestone will be identified. This data will provide the starting point from which progress relating to each task and achievement of milestones will be monitored and measured as indicated above. These baseline data will be compiled at the initiation of the Level One Funding period.

Methods and Their Efficacy to Monitor Progress and Evaluate the Achievement of Program Goals

Current progress in achieving/completing project tasks and milestones is currently monitored by management, discussed in weekly Exchange team meetings and documented in Quarterly Reports submitted to CCIIO. These reports are compiled by OHP's Health Policy Specialist II, Kris Hayslett, who solicits input from the project staff, consultants, and other Kentucky State agencies responsible for specific tasks and milestones. This process has provided effective project management, support, and oversight for the planning efforts thus far and will be extended to include the report of progress relating to Level One funding activities.

1. Project Status Reports
   Project status reports will be formalized, focusing in greater detail on which key tasks and milestones have been completed on schedule, those running behind schedule, and the mitigation strategy for those likely to miss the original scheduled completion date. For each key task and milestone likely to be late, a mitigation strategy will be identified, defining specific actions to be taken to assure completion within a timeline that does not compromise the performance of other tasks and milestones.

2. Deliverables Review
   A detailed deliverables review process will be implemented in order to assure the accurate, complete, and timely provision of project deliverables. The Exchange team is committed to producing and receiving high-quality deliverables from both internal and external sources. We will follow a proven approach to deliverables development, focused on defect prevention and ongoing quality improvement. Core deliverables will be identified and entered into our project management system (computer software). The deliverables' content, schedule, presentation, tracking, and approval process will be

agreed to in advance and documented in the communications plan. Exchange staff will agree upon the specific content, format, and acceptance criteria for all deliverables as well as the timelines and due dates for deliverables' review and completion.

3. Timely Interventions
   If performance and/or deliverables are not provided in an accurate, complete and/or timely manner or Unexpected Obstacles arise/delay the completion of key tasks/deliverables as mutually agreed upon, Kentucky's Project Director, Carrie Banahan lead the project's efforts in monitoring task and milestone progress through completion/provision of deliverables, in addition to meeting the project's overall goals. As previously indicated, the principal tools for monitoring project performance/progress will be the management reports created from project management software noted above, in addition to face-to-face and/or e-mail communication with Exchange staff.

The template below provides an example of an Exchange Issues Management List that will be used for tracking issued being monitored, as well as the current status of key tasks, deliverables, and milestones—both completed and outstanding.

Exchange Issues Management List

Project Lead	Task -- Milestone -- Deliverable	Due Date	Revised Due Date	Problem	Mitigation	Status (Complete, On-Schedule, Late, Seriously Late)

Plan for Ongoing Evaluation of Exchange Functioning Once It Is Operational

If Kentucky decides to seek Level Two funding in the future, an ongoing evaluation plan relating to Exchange tasks, milestones, and deliverables will be developed and submitted for approval of CCIIO, as part of the Level Two funding application.